2004 D-2440 SUB Disability Income Exclusion

042400210000

Round cents to the nearest dollar. If amount is zero, leave the line blank.

OFFICIAL USE ONLY

Leave lines blank that do not apply.

Income If married, complete both columns

123456789 NAME AS SHOWN ON FORM D-40 ABCDEFGHIJKLABCDEFGH YOUR SOCIAL SECURITY NUMBER

Personal information

Date of your birth (MMDDYY) Date you retired (MMDDYY) Payor, if other than employer Name of your employer

ABCDEFGHIJKLABCDEFGH ABCDEFGHIJKLABCDEFGH MMDDYY MMDDYY

Date of spouse's birth (MMDDYY) Date spouse retired (MMDDYY) Name of spouse's employer Payor, if other than employer

ABCDEFGHIJKLABCDEFGH ABCDEFGHIJKLABCDEFGH MMDDYY MMDDYY

Have you filed a physician's certification for this disability in previous years? X NO **X** YES

If yes, you do not have to file another certification. If no, you must file the physician's certification below.

Your spouse Total amount of disability payments received in 2004 \$ 123456789.**00** \$ 123456789.**00**

\$ 123456789.00 \$ 123456789.00 Multiply \$100 by the number of weeks you claimed disability payments in 2004. If you received pay for part of a week, see instructions.

Enter Line 1 or Line 2 amount, whichever is less 3 \$ 123456789.**00** \$ 123456789.**00**

Total Income

4 \$ 123456789.00 Add the Line 3 amounts for you and your spouse.

Limitation on exclusion

5 \$ 123456789.00 Federal adjusted gross income from Form D-40, Line 12.

6 \$ 123456789.00 Taxable social security income from Form D-40 instructions, Calculation A, Line d. 6

Subtract Line 6 from Line 5. 7 \$ 123456789.00

Minus: amount used to reduce disability income - \$15,000.00

9 \$ 123456789.00 Subtract Line 8 from Line 7. If zero or a negative number, stop here.

10 \$ 123456789.00 Disability income exclusion Subtract Line 9 from Line 4.

Enter in Calculation A, Line e. (see Form D-40 instructions) This exclusion may not exceed \$5200

2004 Physician's Certification of Permanent and Total Disability

Name of disabled Social security number

ABCDEFGHIJKLABCDEFGH 123456789

I certify that the above taxpayer was permanently and totally disabled on the date the taxpayer retired (Enter the date retired) MMDDYY

Physician's first name, middle initial, last name

ABCDEFGHIJKLABCDEFGHIJKLABCDEFGHIJKL

Physician's address (number and street) Suite/apartment number

12345ABCDEFGHIJKLABCDEFGH 12ABC

State

123456789 ABCDEFGHIJKLABCDEFGH AΒ

Physician's phone number Physician's Sigtanure Date

1234567890

Attach to Form D-40. See instructions.

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5 6 7 8 9 10 1 1 1 2 1 3 14 15 16 1 7 18 19 20 2 1 22 23 24 25 26 27 28 29 30 3 1 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 65